



# REPORT OF HEARING AND EAR ASSESSMENT

State Form 35055 (R6 / 9-96) / VRS 2051

VOCATIONAL REHABILITATION

**TO EXAMINER(S):** Please send completed report to:

## PART I (to be completed by counselor or applicant)

The information recorded on this form by the VR counselor is to provide the examiner with pertinent background to assist in evaluating the extent of hearing impairment of this referral. It is not to be used for any other purpose.

### GENERAL INFORMATION

Name of applicant (*last, first, middle initial*)

Date of birth

Current occupation:

Home address (*number and street, city, state, ZIP code*)

Telephone number (*home / business including area code*)

Purpose of examination:

### CASE HISTORY

Is the applicant experiencing any of the following conditions? (*medical or other evidence attached - check 3 those that apply*)

- ☐ Visible congenital or traumatic deformity of the ear.
- ☐ History of active drainage from the ear within the previous 90 days.
- ☐ History of sudden or rapidly progressive hearing loss within the last 90 days.
- ☐ Acute or chronic dizziness.
- ☐ Unilateral hearing loss of sudden or recent onset within the previous 90 days.
- ☐ Continuous head noise or ringing in the ears (*tinnitus*).
- ☐ Cerumen accumulation (*ear wax*) or foreign body in the ear canal.

Is there any remarkable ear pathology? (*specify treatment and / or surgery - give types and dates*)

Is the applicant under any medication?

☐ Yes ☐ No

If yes, specify the medication and the reason for which it is being used:

What is the cause of hearing loss and when did it take place? (*This information is to be provided if the applicant is able to answer this question.*)

Is the applicant using a hearing aid?

☐ Yes ☐ No

If yes, specify in what situations the hearing aid is being used:

Is the applicant having difficulty utilizing a hearing aid?

☐ Yes ☐ No

If yes, specify what reason(s):

Is there a family history of hearing impairment or deafness? If yes, what relation(s):

☐ Yes ☐ No

What is the applicant's preferred mode of communication?

- ☐ Discriminating Speech Through a Hearing Aid
- ☐ Sign Language
- ☐ Speechreading
- ☐ Paper and Pencil
- ☐ Braille
- ☐ Tactile Sign

**PART II (To be completed by examiner)**

**HEARING SCREENING (Administered at 20 dB HL)**

Check (4) all those heard.  <b>Right</b> —→  <b>Left</b> —→	<b>500 Hz</b>	<b>1000 Hz</b>	<b>2000 Hz</b>	<b>4000 Hz</b>	
Signature of examiner				Date	

**IF THERE IS A CHECK ( ) IN ALL EIGHT (8) BOXES, DO NOT CONTINUE!**

**PART III (to be completed by physician)**

**DIAGNOSIS**

1. Type of hearing impairment:
<input type="checkbox"/> Sensori-neural <input type="checkbox"/> Conductive <input type="checkbox"/> Mixed <input type="checkbox"/> Central
2. Pathology of hearing loss:
3. Characteristics of hearing impairment: ( <i>check 3 those that apply</i> )
<input type="checkbox"/> Stable <input type="checkbox"/> Fluctuant <input type="checkbox"/> Improving
<input type="checkbox"/> Slowly Progressive    Why?
<input type="checkbox"/> Rapidly Progressive    Why?

**PROGNOSIS AND RECOMMENDATIONS**

1. Prognosis as to receptivity of hearing impairment to treatment:	
2. Treatment recommended - medical, surgery, or other therapy:	
3. New hearing aid(s) recommended?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear	
If so, describe characteristics of amplification:	
4. Are you aware of any hearing-related conditions ( <i>such as Meniere's Disease, Tinnitus, Recruitment, etc.</i> ) which would restrict the type of work activity performed by this individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, please specify condition and related restriction:	
Place:	Signature of Physician
Date ( <i>month, day, year</i> )	Title

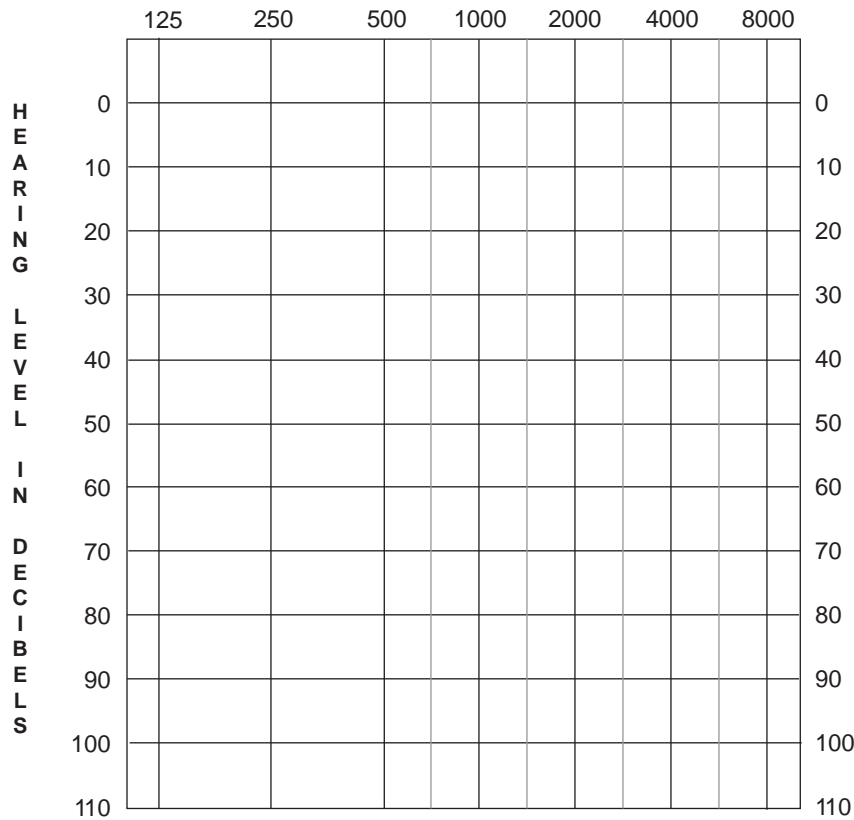
**PART IV (To be completed by examiner)**

**AUDIOMETRIC EXAMINATION**

Instrument used:

Please enter the appropriate symbol for the **right ear in red**; the **left ear in blue**.

Please indicate: ☐ Aided Score and ☐ Unaided Score



**FREQUENCY IN HERTZ (Hz)**

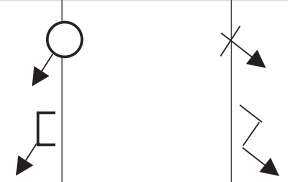
**AUDIOGRAM KEY**

	Right	Left
AC Unmasked	○	×
AC Masked	△	□
BC Mastoid Unmasked	<	>
BC Mastoid Masked	[	]
BC Forehead Masked	┌	┐

**BOTH**

BC Forehead Unmasked	∨
Sound Field	§

**EXAMPLES OF NO RESPONSE SYMBOLS**



PURE TONE AVERAGES			SPEECH AUDIOMETRY	
EAR	Three Frequencies 500, 1000, and 2000 Hz	Four Frequencies 500, 1000, 2000 and 4000 Hz	Speech Reception Threshold (SRT)	
RIGHT	dB	dB	dB	dB
LEFT	dB	dB		

**SPEECH AUDIOMETRY**

Discrimination score to be obtained at 50 dB Hearing Level.			Discrimination score to be obtained at Maximum Comfort Level (MCL) in Quiet.		
EAR	Speech Discrimination Scores		EAR	Speech Discrimination Scores (To be administered in Quiet only)	
RIGHT	Quiet	% at 50 dB HL	RIGHT	MCL	%
LEFT	Quiet	% at 50 dB HL	LEFT	MCL	%
SOUND FIELD	Noise at 0 dB S/N	% at 50 dB HL			

